

FILED JAN 28 1950

STANDARD CERTIFICATE OF DEATH

State File No. 3084

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

672

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2129	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital - 2221 Locust		d. STREET ADDRESS (If rural, give location) 4559a McMillan Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Susie b. (Middle) Mae c. (Last) Taylor		4. DATE OF DEATH (Month) (Day) (Year) Jan. 19 1950	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED; (Specify) Married	8. DATE OF BIRTH Jun. 6, 1912
9. AGE (In years last birthday) 37	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Starksville, Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Buck Jordan		13b. MOTHER'S MAIDEN NAME Callie	
14. NAME OF HUSBAND OR WIFE Cecil Taylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Cecil Taylor	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Intestinal Obstruction</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Generalized Peritonitis</i> DUE TO (c) <i>Pyosalpingitis</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 1/14/50		19b. MAJOR FINDINGS OF OPERATION <i>Pyosalpingitis, Fibroid Ovaries + Appendicitis</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 624X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 1/9, 1950, to 1/19, 1950, that I last saw the deceased alive on 1/19, 1950, and that death occurred at 8:15 p.m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <i>Cecil Taylor</i>		23b. ADDRESS 3133 Bell Ave.	
23c. DATE SIGNED 1/29/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 1-23-1950		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis, Co Missouri		25. FUNERAL DIRECTOR'S SIGNATURE J. H. Randle & Son	
25. ADDRESS 3133 Bell Ave.		DATE REC'D BY LOCAL REG. JAN 22 1950	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer No. 2698

P. O. Address 2767 Charlotte

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.